

Professional Referral Form

Before submitting this form, a referrer MUST ensure the referred person is aware of, and has consented to, being referred to VisAbility Tasmania. A referral cannot be accepted without consent.

Is the referred person aware of, and has consented to, this referral? YES NO

Please complete as much of this form as possible and return to VisAbility Tasmania:

Email:
referrals@guidedogstas.com.au

Mail South:
VisAbility Tasmania
PO Box 82
North Hobart, 7002

Mail North:
VisAbility Tasmania
62 Invermay Road
Invermay, 7248

Fax: (03) 6232 1221

Date: _____

Title: MR MRS MS MISS MASTER Other: _____

First Name: _____ **Middle Names:** _____

Surname: _____ **Date of Birth:** _____

Address: _____

Daytime Phone Number: _____ **Mobile Phone Number:** _____

Funding Sources (if applicable):

- Department of Veterans Affairs (DVA)
- National Disability Insurance Scheme (NDIS)
- Insurance Claim
- Aged Care Package
- Better Start Package
- Other (please provide details below)

Please provide funding details (relevant registration numbers, contact details): _____

Eye condition(s): _____

Visual Acuity: Left: _____ Right: _____

Visual Field Status: _____

Date of last consultation: _____

***** Please include a report from your most recent consultation with the client*****

Ophthalmologist: _____ **Practice Name:** _____

Optometrist: _____ **Practice Name:** _____

General Practitioner: _____ **Practice Name:** _____

Medical Conditions:

- Asthma Arthritis Diabetes Epilepsy
 Heart Condition Hearing Impairment Hearing Aids Worn Other – Please specify

Any other Relevant Information: _____

Assistance requested:

- General Assessment Orientation and Mobility Magnification
 Leisure & Lifestyle Aids & Equipment Activities of Daily Living
 Guide Dog Services Other – Please specify: _____

VisAbility Tasmania will make contact with the client before finalising this referral to gain further details and discuss VisAbility Tasmania services.

Any further information which may assist us to support this client: _____

Where did you find out about VisAbility & Guide Dogs Tasmania Services: _____

Referrers Details:

Name: _____ Provider no: _____

Organisation: _____

Position Title: _____

Address: _____

Phone: _____ Email: _____

*****If you are referring someone under 18 years of age, please complete page 4*****

Child/Under 18 Information

Parent/Guardian Name(s): _____

Address: _____

Phone Number - Home: _____ **Work:** _____

Mobile Phone Number(s): _____

Email Address: _____

Child's Current Grade: _____

School Name: _____ **Phone:** _____

Address: _____

Learning Support Co-ordinator: _____

Phone: _____ **Email:** _____

Class Teacher: _____

Phone: _____ **Email:** _____

Teacher Aid/Assistant: _____

Phone: _____ **Email:** _____

Principal: _____

Phone: _____ **Email:** _____

Resource Teacher/Education Officer - Vision: _____

Phone: _____ **Email:** _____

Contact details of other relevant people involved at school: _____

Does the child receive services from other organisations (eg St Giles, RIDBC)? Details:

Do you have any further information which may assist us to support this child: _____
